Ogata Chiropractic **Ty Ogata, DC**

Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Insurance Company_____

Occupation_____
Employer_____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary reason: Circle
Headache Neck Pain Stiff Neck Lt Shoulder Rt Shoulder Lt Arm Pain R Arm Pain Midback Pain Low Back Pain
Lt Hip Rt Hip Lt Leg Rt Leg Lt Knee Rt Knee other_____

Other reasons: Circle
Headache Neck Pain Stiff Neck Lt Shoulder Rt Shoulder Lt Arm Pain R Arm Pain Midback Pain Low Back Pain
Lt Hip Rt Hip Lt Leg Rt Leg Lt Knee Rt Knee other_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____
_____
_____

3. Past Health History:

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

B. Previous Injury or Trauma:

_____

Have you ever broken any bones? Which?

_____

C. Allergies: _____

D. Medications:

Medication Reason for taking

_____
_____

Patient Name: _____ **Date:** _____

Surgeries:

Date	Type of Surgery

Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death	Age at death

Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Patient Name: _____ Date: _____

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood
□ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Ty Ogata/ Ogata Chiropractic for services performed.

Patient or Guardian Signature _____ Date_____

Patient Name: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply): Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):_____

  Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
- If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____

  Did the symptom begin suddenly or gradually? (circle one)

  How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply): Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other(please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

  Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no

  If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____ Date: _____

PROTECTED HEALTH INFORMATION RELEASE

Please check all that apply and list name(s) of spouse, child(ren) and others involved in care as applicable.

___ You have my permission to leave information on my answering machine regarding my medical care and test results.

___ You have my permission to speak with my spouse about my medical care.

___ You have my permission to speak with my children or other family members involved with my medical care.

___ Other, please describe_____
_____

Name:_____
Relationship:_____
Contact #:_____

Name:_____
Relationship:_____
Contact #:_____

Name Name:_____
Relationship:_____
Contact #:_____

Name:_____
Relationship:_____
Contact #:_____

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient name: _____ DOB:_____

Signature: _____ Date:_____

Patient Name: _____ **Date:** _____

FINANCIAL POLICY

FEES

Regular Chiropractic care fees may include: an exam, x-rays, and spinal adjustments. Additional fees may apply based off the doctor's discretion and may include: extra spinal or extremity adjustments, traction, manual therapy, strapping, laser, and exercises.

GROUP OR INDIVIDUAL INSURANCE

When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment and are **only an estimate**. It is the patient's responsibility to know their benefits. Claim consideration by the insurance company supersedes any information quoted. Patients are fully responsible for payment of any non-covered services, deductibles, and co-pays.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will bill your secondary health insurance plan as well.

MEDICARE

We do accept assignment from Medicare. The services Medicare will cover for Chiropractors is **ONLY** manual manipulation of the spine. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. **Medicare patients are fully responsible for charges of non-covered services.** Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

ON THE JOB INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY/ AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. We will bill your med-pay auto insurance. Notify our insurance department immediately if an attorney is representing you. However, you are ultimately responsible for your bill. Once the claim is settled or if you suspend or terminate care, any fees and services are due immediately.

PATIENTS WITHOUT INSURANCE Patient is responsible for 100% of charges from each visit at the time of service. Our office offers CareCredit as an alternative payment plan. Ask receptionist for more information if this applies to you.

Payment of Account/Credit Guarantee Payment is expected at the time of service. If your account has a balance, you will receive a statement in the mail. Payment, in full, is expected within 30 day. If your account becomes 120 days past due and no payment arrangements have been made, the account will be turned over to collections. **All accounts 60 days past due from the last posted insurance payment will be assessed a 21% finance charge, with a minimum monthly charge of $2.00.**

I have read and understand the payment policy of Ogata Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, **NOT** between Ogata Chiropractic and my insurance company. I request that Ogata Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Ogata Chiropractic that fees will be due and payable immediately. I understand that if I do not give 24 hours notice prior to my scheduled appointment time, I may be billed for my scheduled services.

_____ _____ _____

Patient's Signature (or guardian if patient is a minor) Date Witness